BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

WALTER W. EVANS	)	
Claimant	)	
V.	)	
	)	
CCI	)	
Respondent	)	Docket No. 1,063,777
AND	)	
	)	
TRAVELERS PROPERTY CASUALTY	)	
COMPANY OF AMERICA	)	
Insurance Carrier	)	

ORDER

Claimant requested review of Administrative Law Judge John D. Clark's December 24, 2013 Award. The Board heard oral argument on April 23, 2014. Orvel B. Mason, of Arkansas City, Kansas, appeared for the claimant. Sylvia Penner, of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award. The parties' October 28, 2013 stipulation further indicates the record contains exhibits 3 and 4 of Dr. Gluck's deposition and certain true and correct pages of the AMA *Guides*.[1] The parties attached page 61 of the *Guides* to the stipulation, but part of the text to the right of the page was not photocopied. At oral argument, the parties agreed the stipulation should contain all of page 61.

The parties agreed the Board may consult learned medical treatises showing location of various thumb, hand or wrist joints referenced by the testifying physicians.

While the Award provided claimant permanent partial disability benefits for his upper extremities, the parties agreed Kansas Supreme Court precedent requires compensation to be awarded for each scheduled injury within an impaired upper extremity.

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[1] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment*, (4th ed.). All references are to the 4th ed. of the *Guides* unless otherwise noted. The parties cannot cite the *Guides* without the *Guides* having been placed into evidence. See *Durham v. Cessna Aircraft Co.*, 24 Kan. App. 2d 334, 334-35, 945 P.2d 8, *rev. denied* 263 Kan. 885 (1997). The Board has ruled against exploring and discussing the *Guides*, other than using the Combined Values Chart, unless relevant sections of the *Guides* were placed into evidence. See *Billionis v. Superior Industries*, No. 1,037,974, 2011 WL 4961951 (Kan. WCAB Sep. 15, 2011). Respondent would allow the Board to take judicial notice of the *Guides* in determining this matter, but claimant objected, noting he first wanted to know which sections of the *Guides* the Board might reference.

The parties disagreed whether the carpometacarpal (CMC) joint is in the wrist. Claimant stated at oral argument the CMC joint is in the wrist, while respondent indicated it is in the thumb.

The parties agreed the Award should not have given respondent credit for having paid 0.86 weeks of temporary total disability (TTD) benefits twice, when respondent only paid 0.86 weeks of TTD once.

ISSUES

The parties stipulated claimant sustained work-related injuries to his bilateral upper extremities from February 1, 2009 through May 5, 2009. The judge awarded claimant permanent partial disability benefits based on a 14% impairment to the right upper extremity and a 14% impairment to the left upper extremity based on the treating physician's opinion instead of claimant's hired medical expert's opinion.

Claimant requests the Award be modified, arguing the treating doctor's rating is inconsistent with the *Guides* and his expert's rating is more credible. Claimant asserts his disability benefits must be separately calculated for his thumbs, forearms and arms, not simply to his upper extremities. Claimant also requests a $74.05 underpayment of TTD benefits. Respondent maintains the Award should be affirmed.

The issues for the Board's review are:

1) Is claimant entitled to additional TTD benefits?

2) What is the nature and extent of claimant's disability?

FINDINGS OF FACT

Respondent is a manufacturing plant that builds industrial silencers and mufflers. For approximately 20 years, claimant has worked for respondent as a machinist, primarily drilling holes in pipes, which requires repetitive use of his hands.

In early-2009, claimant began experiencing numbness, tingling and pain in his fingers and wrists, and cramping in the base of his thumbs. He initially sought treatment from his family physician, who prescribed splints. Claimant was also seen by a couple referral physicians and he had a couple EMG tests.

Claimant notified respondent of his work-related injuries after being asked by his supervisor why he was wearing splints at work. Respondent then authorized medical treatment, which resulted in claimant being referred to James Gluck, M.D., a board certified orthopedic surgeon with an added qualification in hand surgery.

Claimant was seen by Dr. Gluck on May 6, 2009, for pain in both thumbs and numbness in both hands. Dr. Gluck initially provided conservative treatment, including physical therapy, injections, splints, work limitations and medication. When such treatment failed to provide relief, Dr. Gluck performed right upper extremity surgery, including a carpal tunnel release and carpometacarpal (CMC) joint arthroplasty, on January 12, 2010. Dr. Gluck characterized the CMC arthroplasty as a joint replacement at the base of the thumb.[2] Dr. Gluck agreed with claimant's attorney that the "carpal metacarpal joint" is "down right near your wrist."[3] Claimant was off work from January 12 through January 18, 2010. Next, claimant underwent physical therapy and was discharged on March 22, 2010, with documented thumb and wrist range of motion deficits, along with strength deficits.

Claimant told Dr. Gluck he had improvement in his right-sided symptoms and he wanted to proceed with the same procedures on his left upper extremity, which Dr. Gluck performed on January 15, 2011. Claimant was off work from January 25, 2011 through January 31, 2011. Again, claimant underwent physical therapy and was discharged on April 7, 2011, with thumb and wrist range of motion deficits, along with strength deficits.

On July 14, 2011, Dr. Gluck released claimant at maximum medical improvement. At the time of his release, claimant was reporting an 80% improvement in his CMC joint pain and a 70% improvement in function bilaterally. While Dr. Gluck did not personally measure claimant's range of motion using a goniometer, he believed claimant had good range of motion based upon his observations.

Dr. Gluck assigned claimant a 14% impairment to each upper extremity consisting of 11% impairments for the CMC joint arthroplasties, using Table 27 of the *Guides*, and 5% impairments to each hand, or 3% to the upper extremities, for the carpal tunnel releases. Dr. Gluck restricted claimant to avoid repetitive or forceful pinching with his thumbs.

Dr. Gluck did not consider range of motion or strength loss in arriving at his rating. Dr. Gluck opined such deficits were already accounted for by claimant's CMC arthroplasty impairment ratings:

> Q. So he still has a grip strength loss?
>
> A. Correct. But just to be clear, too, as you know, the guides say that you need to use one measure for impairment and if there is impairment that is contained within a measurement, you can't then use another measurement and add those two together. So you can't use strength and arthroplasty if the arthroplasty is expected to have strength loss. So that impairment in the arthroplasty impairment includes loss of motion, loss of strength.

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[2] See Gluck Depo. at 8.

[3] *Id.* at 15.

Q. Well, now, the guides do provide, do they not, that range of motion losses are to be added to the 11 percent that's in Table 27?

A. Only if it's an additional beyond what you'd expect. Because after an arthroplasty, you wouldn't expect a completely normal joint. That's why you have an impairment rating. And so that impairment - - when you say, well, why do you get an impairment for arthroplasty, didn't you make it normal? No. Well, why is it not normal? Because they don't get back normal motion and completely normal strength.

Q. I'm looking at page 3-62 of the guides, Doctor. On page 3-61 it has Table 27 and it's talking about arthroplasty, correct?

A. Correct.

Q. And on page 3-62 it says, "In the presence of decreased motion, motion impairments are derived separately and combined with arthroplasty impairments," is that accurate?

A. It says you can, yes, but if you look at the very front of the book, one of the - - and I can't find it off the top of my head, but it says that you can't - - or you should not - - again, this is a guide. So it's not an absolute, it's a guide.

Q. Right.

A. And that the recommendation is that if the impairment is contained within one way to measure it, you shouldn't add something else that is contained within. And by my interpretation, that's contained within that because these are pretty significant upper extremity impairment rating percentages when you look at other losses to put them into relative perspective.

Q. Okay. So your interpretation of the guides is that if there's a range of motion that you think is appropriate for that procedure, then you don't determine the range of motion separately and add it.

A. To the impairment, that's correct.[4]

Dr. Gluck testified his ratings for claimant's bilateral carpal tunnel syndrome were not based on Table 16 of the *Guides* because, in his opinion, use of such chart was inapplicable where the patient does not have neurological symptoms. He testified claimant had "resolution" or "complete resolution" of his neurological symptoms.[5] Dr. Gluck's assigned carpal tunnel ratings were based on an alteration in claimant's anatomy following surgery.

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[4] *Id*. at 21-23.

[5] *Id*. at 23-24.

At the time of the regular hearing, claimant testified he takes pain medication for everyday wrist and thumb pain. He has scars at the base of his thumbs, but he did not testify if his scars went into his wrists. He complained of pain at the base of his thumbs and his thumb joints, as well as in his wrists or forearms. He noted numbness in his wrists, hands and fingers. He continues to work his normal job duties. As part of his job, he frequently uses a chuck key to change drill bits. After the accident, he modified the chuck key so he can push with his palm instead of using his thumb. Aside from this modification, claimant is able to carry out his job. Claimant testified that work makes his pain worse.

Claimant was seen at his attorney's request by George Fluter, M.D., who is board certified in physical medicine and rehabilitation, as well as certified as an independent medical examiner. Claimant complained of bilateral hand, thumb, wrist and forearm symptoms. Dr. Fluter diagnosed claimant with bilateral upper extremity pain, cumulative trauma/repetitive use disorder, thumb pain and carpal tunnel syndrome, all causally related to his work. After measuring claimant's lost upper extremity range of motion using a goniometer, Dr. Fluter assigned the following impairment ratings based on the *Guides*:

- 22% impairment to the right thumb and 18% impairment to the left thumb for deficits in range of motion, including the interphalangeal (IP) and metacarpophalangeal (MP) joints;

- 5% to the right wrist and 4% to the left wrist for range of motion deficits; and

- 20% to each upper extremity for moderate postoperative degree of median nerve entrapment at the left and right wrists.

Dr. Fluter provided permanent restrictions of: lifting, carrying, pushing, pulling up to 20 pounds occasionally and 10 pounds frequently; grasping using each hand on an occasional basis and repetitive flexion and extension of each wrist on an occasional basis; occasional use of power/vibratory tools with each hand; use appropriate thermal protection for the hands when working in cold environments; and avoid repetitive or forceful pinching with the right and left thumbs.

At his deposition, Dr. Fluter amended his rating to include an additional 11% impairment to each upper extremity for the CMC joint arthroplasties. Dr. Fluter testified a CMC joint arthroplasty involves removal of an arthritic portion of the thumb and claimant's procedures also involved ligament reconstruction and interposition of a tendon at the base of the thumbs. Dr. Fluter testified claimant's CMC procedures were performed where the thumb joins or articulates with the bones in the wrist at the metacarpal joint.[6] When including claimant's CMC surgeries, Dr. Fluter opined claimant had a 34% right upper extremity impairment and 36% left upper extremity impairment.

[6] Fluter Depo. at 14-15; see also pp. 21-22.

Dr. Fluter testified that while the range of motion model tends to be the preferred method for limb rating joints, the *Guides* specifically state that a range of motion impairment should be combined with an arthroplasty impairment:

> Q. But when you do an arthroplasty in a joint you can also use the diagnosis related ratings, can't you?
>
> A. That's correct. That is one area where the Guides specifically says that you can combine an arthroplasty impairment with a range of motion impairment. Most of the other ones you can't. There is a - - well, if a range of motion is normal then you can use the diagnosis related impairment. But if the range of motion is not normal then use the range of motion and do not combine it with the diagnosis related impairment. But arthroplasty is an exception, that's one where the Guides actually specifically states that you can use, you can combine an arthroplasty impairment with range of motion impairment.
>
> Q. And, in fact, it doesn't say that you can do it, it says that you are supposed to?
>
> A. Right. If you have a range of motion deficit in the setting of an arthroplasty, yes, you combine them.[7]

Page 62 of the *Guides* provides an example of calculating impairment in which range of motion impairments are combined with arthroplasty impairments. Such page, under the category, "Arthroplasty," also states:

> In the presence of decreased motion, motion impairments are derived separately (Sections 3.1f through 3.1j) and *combined* with arthroplasty impairments using the Combined Values Chart (p. 322).[8]

When asked whether claimant's symptoms as reported at the regular hearing were consistent with "continued aggravation . . . , of his thumbs, and with a moderate degree of carpal tunnel symptoms remaining in his hands," Dr. Fluter answered:

> Sure. I think that would be consistent with that, the types of, it sounds like he's doing the same types of activities that he was doing that sort of lead to the problem in the first place.[9]

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[7] *Id*. at 16-17.

[8] Stipulation filed Oct. 28, 2013.

[9] Fluter Depo. at 35.

PRINCIPLES OF LAW

K.S.A. 2009 Supp. 44-501(a) states in part:

In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends.

K.S.A. 2009 Supp. 44-508(g) defines burden of proof as follows:

"Burden of proof" means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.

K.S.A. 44-510d states in part:

(a) Where disability, partial in character but permanent in quality, results from the injury, the injured employee shall be entitled to [medical compensation], but shall not be entitled to any other or further compensation for or during the first week following the injury unless such disability exists for three consecutive weeks, in which event compensation shall be paid for the first week. Thereafter compensation shall be paid for temporary total loss of use and as provided in the following schedule, 66⅔% of the average gross weekly wages to be computed as provided in K.S.A. 44-511 and amendments thereto, except that in no case shall the weekly compensation be more than the maximum as provided for in K.S.A. 44-510c and amendments thereto. If there is an award of permanent disability as a result of the injury there shall be a presumption that disability existed immediately after the injury and compensation is to be paid for not to exceed the number of weeks allowed in the following schedule:

(1) For loss of a thumb, 60 weeks.

. . .

(11) For the loss of a hand, 150 weeks.

(12) For the loss of a forearm, 200 weeks.

(13) For the loss of an arm, excluding the shoulder joint, shoulder girdle, shoulder musculature or any other shoulder structures, 210 weeks . . . .

. . .

(23) Loss of a scheduled member shall be based upon permanent impairment of function to the scheduled member as determined using the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

K.A.R. 51-7-8(c) states, in part:

> (1) An injury involving the metacarpals shall be considered an injury to the hand. An injury involving the metatarsals shall be considered an injury to the foot.
>
> . . .
>
> (4) An injury at the joint on a scheduled member shall be considered a loss to the next higher schedule.

Administrative regulations have the force and effect of law and are presumed valid if within the statutory authority conferred upon the agency, and appropriate, reasonable, and not inconsistent with the law.[10]

K.S.A. 44-510e(a) states, in part:

> Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

"[A]n impairment rating must comply with the AMA *Guides* to be considered in determining the claimant's disability."[11] Use of the *Guides* is meant "to bring greater objectivity to estimating permanent impairments "by performing medical evaluations 'in accordance with the directions in the Guides.'"[12] Where the *Guides* do not account for an impairment, a physician may use his judgment to formulate an opinion regarding impairment[13] and a physician may "exercise some discretion to arrive at what the physician believes is an accurate impairment for the injuries sustained by the patient."[14]

The *Guides* and Kansas law do not always fit nicely together. The *Guides* provide ratings to the upper extremity, while our statutory schedule does not list the "upper extremity," instead listing the finger, thumb, hand, forearm, arm and shoulder.

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[10] See *Hall v. Knoll Bldg. Maintenance, Inc.*, 48 Kan. App. 2d 145, 150, 285 P.3d 383 (2012).

[11] *Pierce v. L7 Corporation/Wilcox Painting*, No. 103,143, 2010 WL 3732083 (Kansas Court of Appeals unpublished opinion filed Sep. 17, 2010).

[12] *Redd v. Kansas Truck Ctr.*, 291 Kan. 176, 191, 239 P.3d 66 (2010) (quoting *Guides*, p. v. and *Guides* § 1.2, p. 3).

[13] See K.S.A. 44-510e(a); See *Smith v. Sophie's Catering & Deli Inc.*, No. 99,713, 2009 WL 596551 (Kansas Court of Appeals unpublished opinion filed Mar. 6, 2009, *publication denied* Nov. 5, 2010).

[14] *Pierce*, supra.

Strict adherence to the *Guides* should not be used to circumvent awarding permanent partial disability benefits for specific scheduled injuries under K.S.A. 44-510d.[15] When there is a conflict between the *Guides* and K.S.A. 44-510d, the statute controls. An award of permanent partial disability (PPD) benefits must be based on the actual situs of the disability based on Kansas law, which classifies different parts of the upper extremity as warranting different sets of maximum weekly benefits under the schedule.

"It is the function of the district court to decide which testimony is more accurate and/or credible, and to adjust the medical testimony along with the testimony of the claimant and any other testimony which may be relevant to the question of disability."[16] From July 1, 1993 forward, the Board assumed the role of the district court.[17]

ANALYSIS

1. Claimant is entitled to one additional day of TTD benefits.

Claimant was off work for a total of two weeks due to his 2010 and 2011 surgeries. The first week of TTD is not payable unless an employee is off work for three consecutive weeks. Claimant was not off work for three consecutive weeks. However, claimant is entitled to TTD for the entire second week he was off work. The weekly rate was $529. Claimant was paid $454.94. The difference of 0.14 weeks would result in an additional payment of $74.06. Claimant is awarded an additional 0.14 weeks of TTD, or $74.06.

2. Claimant sustained a 24% right forearm impairment, a 23% left forearm impairment, a 15% right thumb impairment and a 12% left thumb impairment. Claimant did not prove permanent hand impairment.

Claimant's permanent partial disability benefits must be calculated in accordance with Kansas Supreme Court precedent stating K.S.A. 44-510d requires compensation for each scheduled injury when multiple injuries occur within a single upper extremity. While the ratings provided by the physicians may be consistent with the *Guides'* directives, they are not consistent with what Kansas law requires. Dr. Gluck's lumping together all of claimant's impairment as involving the upper extremity, while proper under the *Guides*, is improper under Kansas law. Also, contrary to Dr. Fluter's opinion, claimant does not have impairment at a level higher than his forearms.

The Board will address the particulars of claimant's various impairments as follows.

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[15] See *Redd,* 291 Kan. at 196-98; see also *Mitchell v. PetSmart, Inc.*, 291 Kan. 153, 166, 239 P.3d 51 (2010).

[16] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 786, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

[17] See *Hall v. Roadway Express, Inc.*, 19 Kan. App. 2d 935, 939, 878 P.2d 846 (1994).

A. *Forearm Impairment*

Claimant's right forearm impairment is based on carpal tunnel syndrome residuals, CMC impairment and wrist range of motion deficit.

i. *Carpal Tunnel Syndrome Impairment*

While Dr. Gluck testified his rating for claimant's bilateral carpal tunnel syndrome was based on the *Guides*, his report and his testimony provide little or no real support. He cited Table 27 for claimant's CMC rating, but did not cite any part of the *Guides* concerning claimant's carpal tunnel syndrome. Dr. Gluck is not required to cite chapter and verse of the *Guides*, but the Board may judge the credibility of an impairment rating based on a doctor's inclusion or exclusion of *Guides* in his or her analysis.[18] Dr. Gluck was questioned regarding how his carpal tunnel ratings were based on the *Guides*. He testified his carpal tunnel ratings were based on "some effect to the upper extremity . . ."[19] and "some alteration in the anatomy."[20] Dr. Gluck's carpal tunnel ratings seem based more on physician judgment and not grounded in use of the *Guides*.

The *Guides* provide methods to rate entrapment neuropathy, such as carpal tunnel syndrome, based on sensory and motor deficits, as noted in the parties' stipulation (see page 55 of the *Guides*). An alternative method is in Table 16. Dr. Gluck did not cite any portion of the *Guides* in arriving at his carpal tunnel ratings. Under Table 16, a 10% upper extremity rating is appropriate for median nerve entrapment neuropathy of mild severity and a 20% impairment is appropriate for median nerve entrapment neuropathy of moderate severity. Table 16 does not contain a 5% hand or 3% upper extremity impairment, as was provided by Dr. Gluck.

Dr. Gluck's carpal tunnel rating was also based on the theory that claimant's numbness and tingling from CTS had "resolved"[21] and he could not use Table 16 of the *Guides* to provide median nerve impairment because of his belief claimant "felt there was resolution of his neurologic symptoms."[22] Such belief was mistaken. Indeed, claimant still reported left hand numbness along the median nerve distribution when seen by Dr. Gluck on April 7, 2011. Claimant further testified that he did not have resolution of his bilateral upper extremity numbness and tingling.

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[18] *Ricks v. Catholic Care Center*, No. 95,979, 2007 WL 220108 (Kansas Court of Appeals unpublished opinion filed Jan. 26, 2007).

[19] Gluck Depo. at 12.

[20] *Id.* at 24.

[21] *Id.* at 10.

[22] *Id.* at 23-24.

Claimant argues Dr. Gluck's rating is stale. However, a fair argument can be made that Dr. Fluter's carpal tunnel ratings are too temporally remote. Dr. Fluter's rating was provided two years after claimant's left upper extremity surgeries and three years after claimant's right upper extremity surgeries. Claimant testified his ongoing work makes his pain worse, while Dr. Fluter testified claimant had continued aggravation from his ongoing work duties. The Board is concerned that claimant's condition worsened in the intervening years. Given this concern, the Board will not simply adopt Dr. Fluter's CTS rating over that of Dr. Gluck's CTS rating. The Board, which under *Tovar* is charged with adjusting the medical and lay testimony in determining a claimant's disability, concludes claimant sustained mild bilateral carpal tunnel residuals from his 2009 accidental injury by repetitive motion. The *Guides* provide a 10% rating for such condition. Such conclusion is a compromise between Dr. Gluck's indication claimant had no neurologic residuals and Dr. Fluter's opinion claimant had severe impairment. Under our statutory schedule, claimant's CTS impairment is limited to his forearms.

ii. *Carpometacarpal Joint and Wrist Range of Motion Impairment*

According to Dr. Fluter, the CMC joint connects to the wrist.[23] Claimant's CMC arthroplasty was performed at the joint between the base of the thumb and the wrist bones.

K.A.R. 51-7-8(c)(4) states an injury at the joint is an injury to the next higher level. Given that an injury to the CMC joint is an injury to the joint, the injury shall be considered a loss to the next higher schedule, the forearm. While both Drs. Gluck and Fluter followed the *Guides* in providing an 11% "upper extremity" rating for a CMC arthroplasty, any such rating must be to the forearm, not the arm. Further, while the record is replete with references to the CMC surgery being a "thumb" surgery, the administrative regulation noted above requires claimant's impairment to be calculated based on the forearm.

Dr. Gluck's testimony that the *Guides* do not allow a rating for both a specific surgical procedure and range of motion deficits is incorrect. The *Guides* specifically allow a rating for a CMC arthroplasty and range of motion deficits.[24]

Claimant has a 24% impairment to the right forearm, including 11% for CMC arthroplasty, 10% for mild severity carpal tunnel syndrome/median nerve residuals and 5% for wrist ROM deficits. Claimant has a 23% impairment to the left forearm, including 11% for CMC arthroplasty, 10% for mild severity carpal tunnel syndrome/median nerve residuals and 4% for wrist ROM deficits. Under the Combined Values Chart in the *Guides*, such figures are combined, not added together. Combining impairment is not synonymous with adding impairment.

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[23] See Fluter Depo. at 14-15; see also http://www.mayoclinic.org/carpal-bones/img-20007898. The Board considers such website to provide the equivalent of a learned medical treatise.

[24] See Fluter Depo. at 16-17, 19, 25.

B. *Potential Hand Impairment for the Metacarpophalangeal Joint*

The *Guides* indicate MP joint impairment involves the thumb. However, K.A.R. 51-7-8(c)(4) states an injury to the joint must be computed to the next higher level. The MP joint articulates with the thumb metacarpal and is the joint between the thumb metacarpal and the proximal phalanx. K.A.R. 51-7-8(c)(1) states that an injury involving the metacarpals shall be considered an injury to the hand. Given that a joint injury is to the next level and our regulation states the metacarpal is considered the hand, an MP joint impairment is to the hand, even though the *Guides* say differently.

However, determining claimant's MP joint impairment is problematic. Dr. Fluter gave a combined rating for claimant's MP joint and IP joint range of motion deficits. MP joint impairment would be to the hand, but IP joint impairment would be to the thumb. Dr. Fluter commingled the impairments for different body parts under the schedule. The Board could likely ascertain claimant's separate IP and MP joint impairments by consulting the *Guides*, but the parties did not agree the Board could take judicial notice of the *Guides*. The Board cannot determine the separate impairments without consulting sections of the *Guides* that were not included in the parties' stipulation.

C. *Thumb Impairment*

Claimant has a 15% impairment to the right thumb due to ROM deficits (1% adduction, 1% abduction and 13% opposition) and a 12% impairment to the left thumb for ROM deficits (3% adduction and 9% opposition). Under the *Guides* these figures are added together, not combined. For the reasons listed in the preceding paragraph, the Board ascertain claimant's additional thumb impairment based on the IP joint.

CONCLUSIONS

Claimant's disability benefits must be calculated separately. Respondent's credit for one week of TTD benefits will be evenly split between the two left upper extremity impairments. Claimant's indemnity benefits are as follows:

- $25,392 for 24% impairment to the right forearm (200 weeks x 24% = 48 weeks x $529 = $25,392);
- $4,761 for 15% impairment to the right thumb (60 weeks x 15% = 9 weeks x $529 = $4,761);
- $24,275.81 for 23% impairment to the left forearm (200 weeks - 0.5 weeks TTD = 199.5 weeks x 23% = 45.89 weeks x $529= $24,275.81); and
- $3,777.06 for 12% impairment to the left thumb (60 weeks - 0.5 weeks TTD = 59.5 weeks x 12% = 7.14 weeks x $529 = $3,777.06).

Claimant's total award for his right and left upper extremity impairments is $58,205.87. The Board otherwise affirms the Award in all other respects.

AWARD

WHEREFORE, having reviewed the entire evidentiary file contained herein, the Board modifies the December 24, 2013 Award as listed in the prior section. All permanent partial disability benefits are currently due and owing.

IT IS SO ORDERED.

Dated this _____ day of May 2014.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

c: Orvel B. Mason
aroach@ompa.kscoxmail.com

Sylvia B. Penner
spenner@fleeson.com

Ali N. Marchant
amarchant@fleeson.com

Honorable John D. Clark